Patient-Centered Medical Home and the Future of Medical Care in Montana

A series of Webinars for the Primary Care Providers of Montana created and presented by the Primary Care Providers of Montana

Monica J. Lindeen
CSI
Montana Commissioner of Securities & Insurance

Patient-Centered Medical Home Advisory Council

- An initial stakeholder group was convened through DPHHS in 2009, I reformed the group into an official state advisory council to provide guidance on advancing development of PCMH in Montana.
  - 25 members: Payers, Providers, Consumers, Interested Parties;
  - 100 on the mailing list
- Completed Work Products:
  - Definition
  - Standards for Recognition
  - Framework for Payment
  - **Quality Metrics for Performance Measurement (Today's Webinar)**
- On-going Work:
  - Education & Advocacy
  - Enabling Legislation for sustainability

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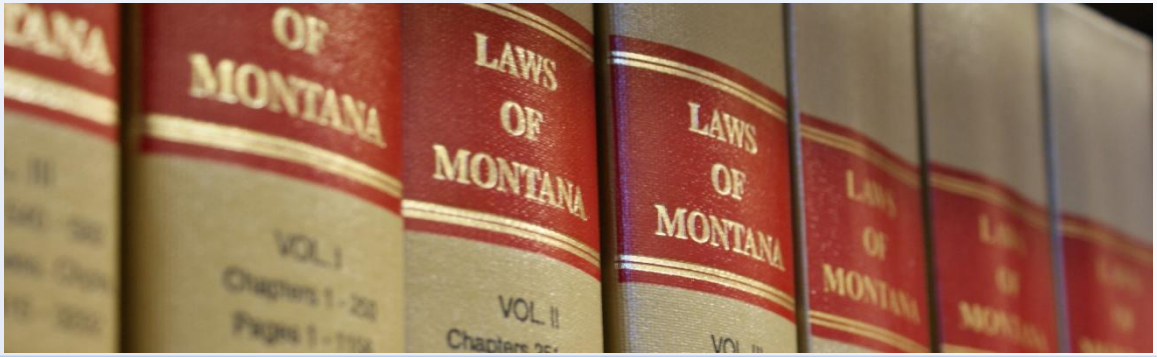
Legal Issues

- Federal and state anti-trust laws prohibit collusion between insurers on prices
- Anti-trust laws maintain competition and benefit consumers through lower prices, more choices, and greater innovation
- The PCMH model, however, requires insurers to agree on a collaborative approach to payment
- The advisory council recommended legislation for 2013 to exempt the Montana PCMH program from anti-trust laws



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PCMH Bill Draft

The advisory council's recommended legislation would:

- Authorize the creation of a PCMH program in Montana
- Establish a 9-member governing commission under the supervision of the CSI
  - Commission would include representatives of health plans, consumer advocates and primary care
- Codify the definition of PCMH
- Allow the commission to recognize patient-centered medical homes that meet standards the commission develops
- Link to the bill draft on the CSI website
  - Please share with your colleagues, we are interested in your feedback

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PCMH Characteristics

Accountability at individual patient, panel, & population levels for:

- Comprehensive primary care services
- Care coordination and follow-up (chronic diseases)
- Long term care continuity

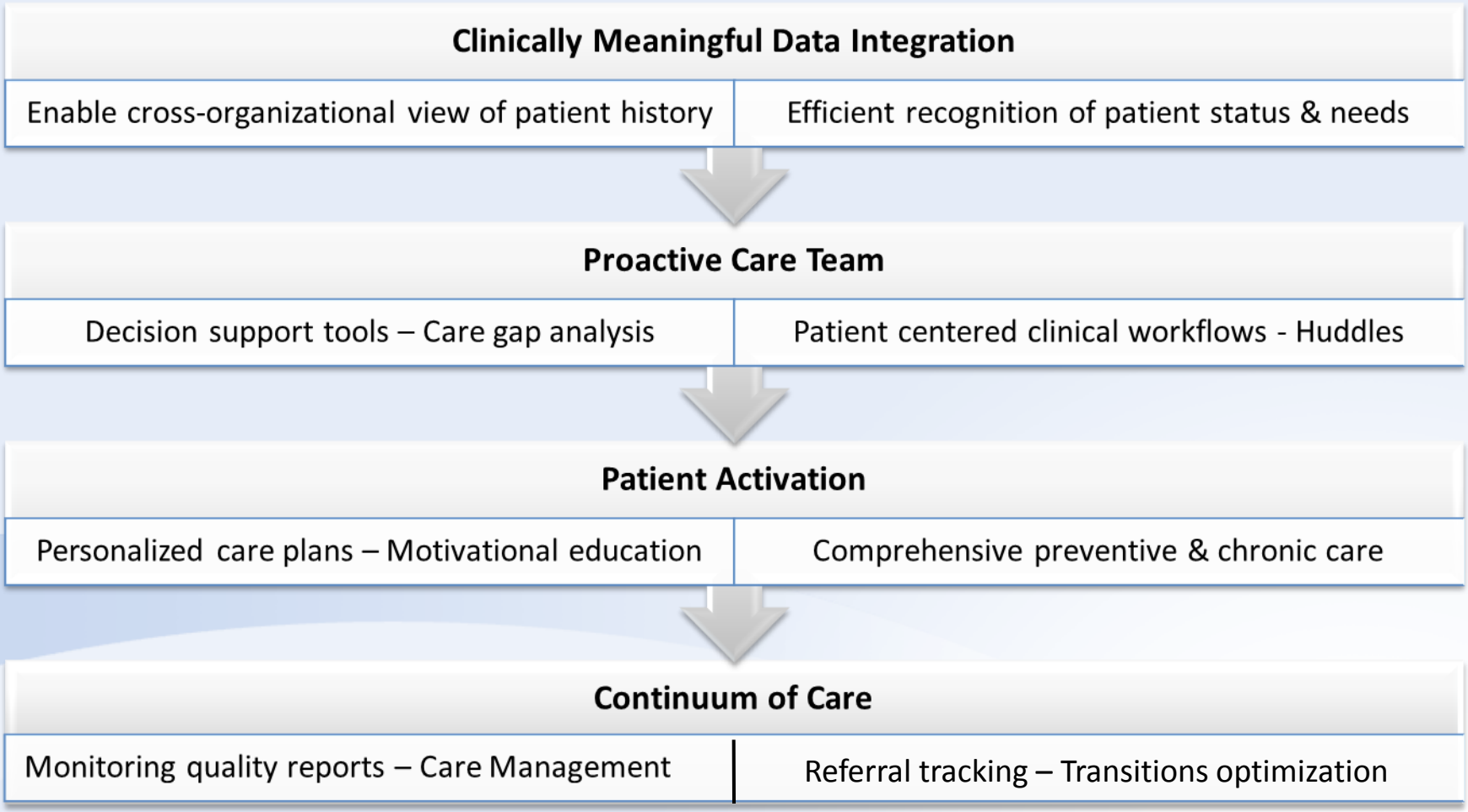
Patient-centered care improvement through measured:

- Access to care
- **Clinical Quality Metrics**
- Patient satisfaction

Health delivery system transformation:

- Team approach *(function at level of license)*
- Care management *(activities not reimbursed under FFS)*
- Technological infrastructure & data use

PCMH Quality Elements



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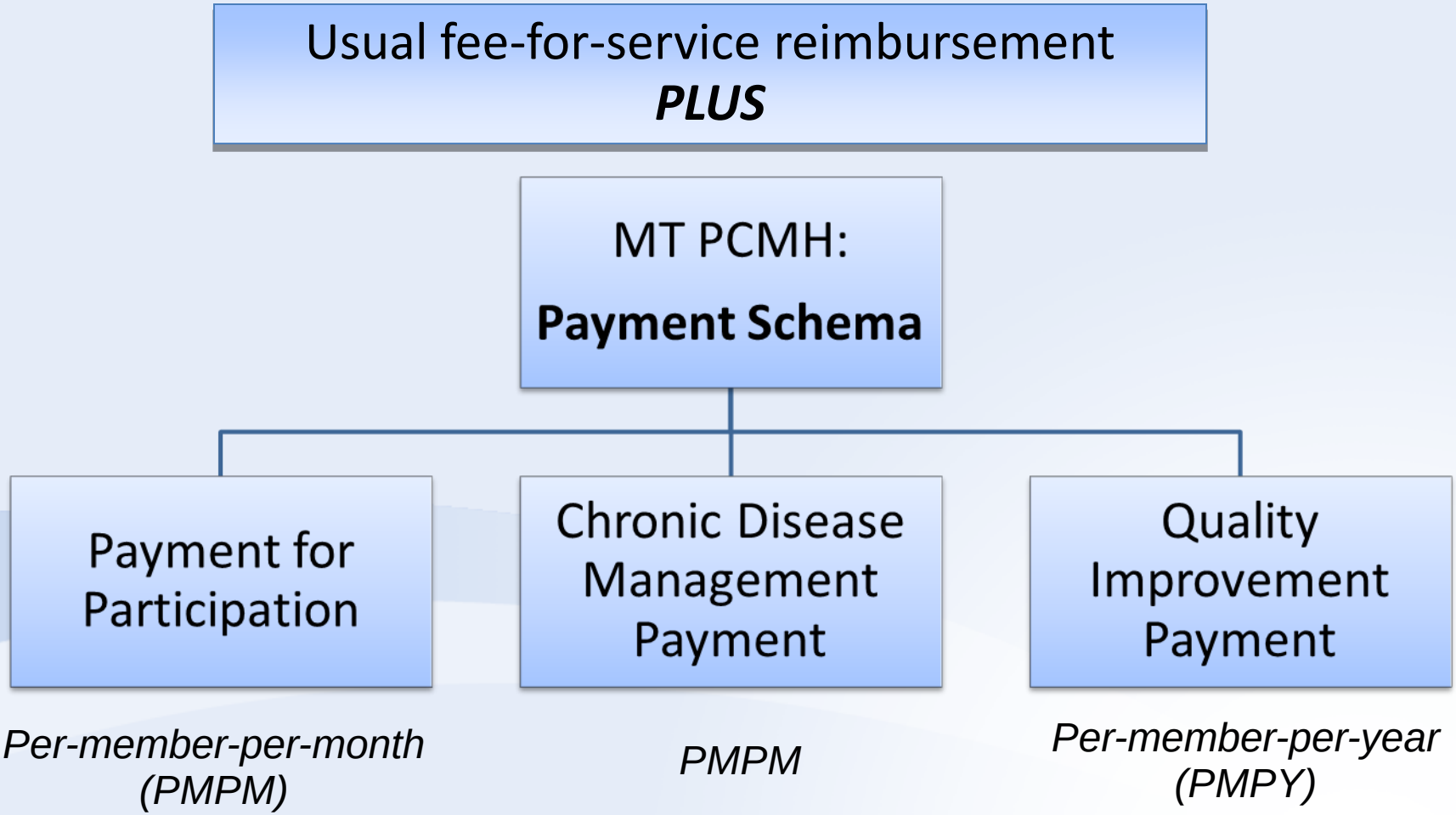
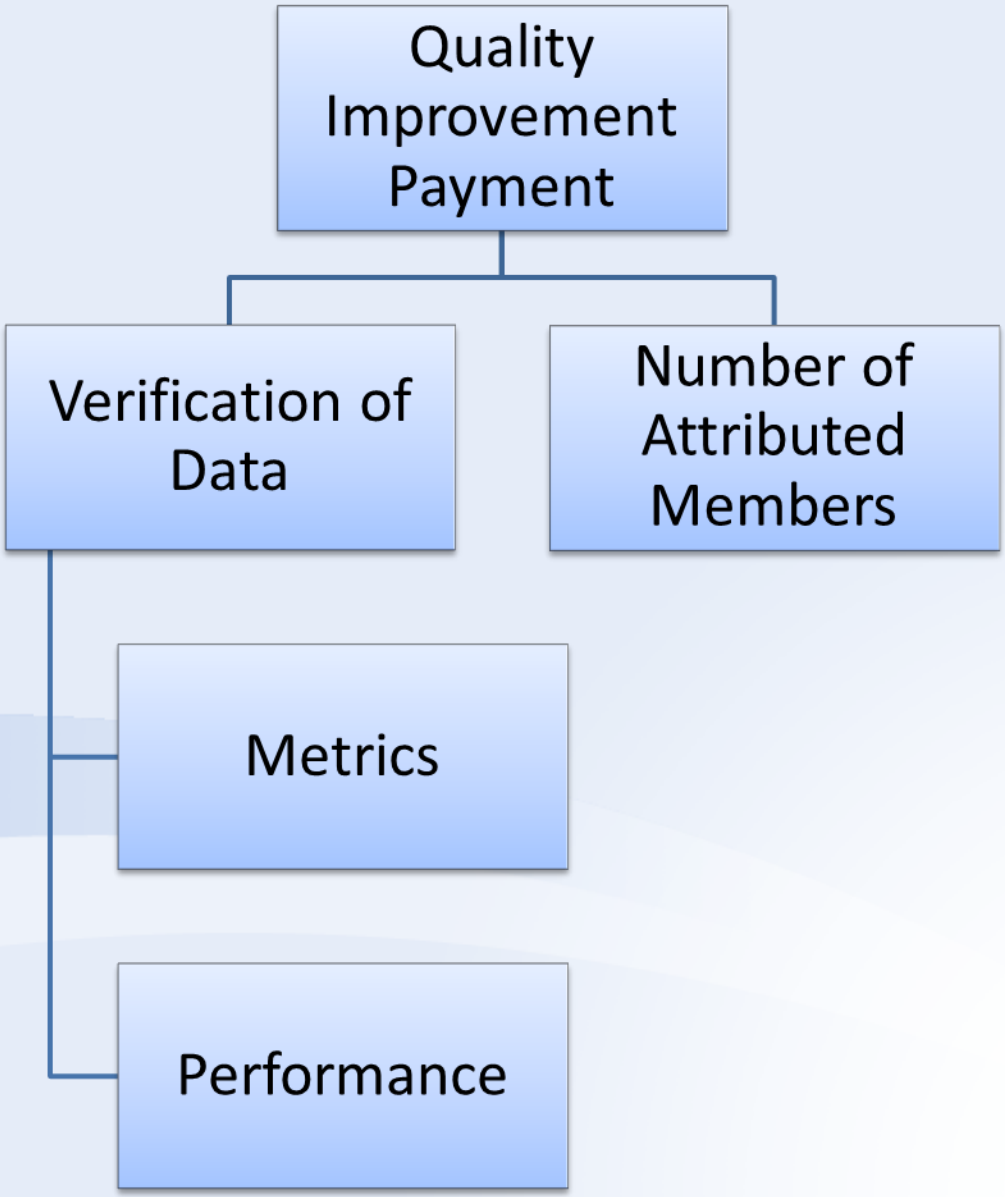
PCMH Incentives




Quality Improvement Payment
Verification of Data
Number of Attributed Members
Metrics
Performance

Quality Bonus

- Standardized reporting and analysis
  - Statewide
  - Credible and accountable
  - Statistically valid
- Established through evidence-based best practices
- Quality targets for bonuses
  - Set by Advisory Council or governing body.
- Amount of Bonus
  - Set by payers

Reconciling Guidelines and Quality Measures

Developing guidelines that address a wide range of needs…

Low-Risk Patients

Higher Risk Patients

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Initial Stakeholders Analysis

- Patient Demographics
  - 21 Items → Name, contact info, etc.
  - 6 Items related to Patient Measurements
    - Ht, Wt, BMI, etc.
  - 3 Items related to Access and Appointment Monitoring
  - CAHPS Survey
  - Drug Use
    - 10 items on Tobacco use
    - 13 items on Alcohol Use
    - 10 items on Drug Abuse

Initial Stakeholders Analysis

- Preventive Health Measures
  - 22 Preventive Health Measures
    - Vaccines
    - Screening
    - Depression Screening

Initial Stakeholders Analysis

- Chronic Disease
  - Cardiovascular Disease - 8 items
  - CHF - 10 items
  - DM Adult, Adolescent and Child - 12 items
  - HTN Adult and Child - 9 items
  - Asthma - 4 items
  - Medication Monitoring - 8 items

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Initial Stakeholders Analysis

- Final Tally -- 175 Measurements
- Everyone agreed
  - All useful
  - All evidence based
  - All clinically significant
- Way too many, particularly at the start of a pilot program

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Dr. Jon Griffin

- Jonathan Griffin, M.D., earned his Medical Degree in 2008, and a Masters of Science in Health Administration in 2006, both from the University of Washington School of Medicine. He completed a family medicine residency in Boise, Id. Dr. Griffin also holds Bachelor of Science degrees in biology and communications, and a minor in chemistry from Carroll College.
- He is current board member of the Idaho Academy of Family Physicians and a member of the Patient Centered Medical Home Pilot Project Development and Implementation Team. In 2010, he was a Resident Delegate for the American Academy of Family Physicians National Conference. Dr. Griffin and his wife have three sons are happy to be back home in Montana.
- Vice-Chair of the MT PCMH Advisory Council
- Chair of the Quality Metrics Subcommittee

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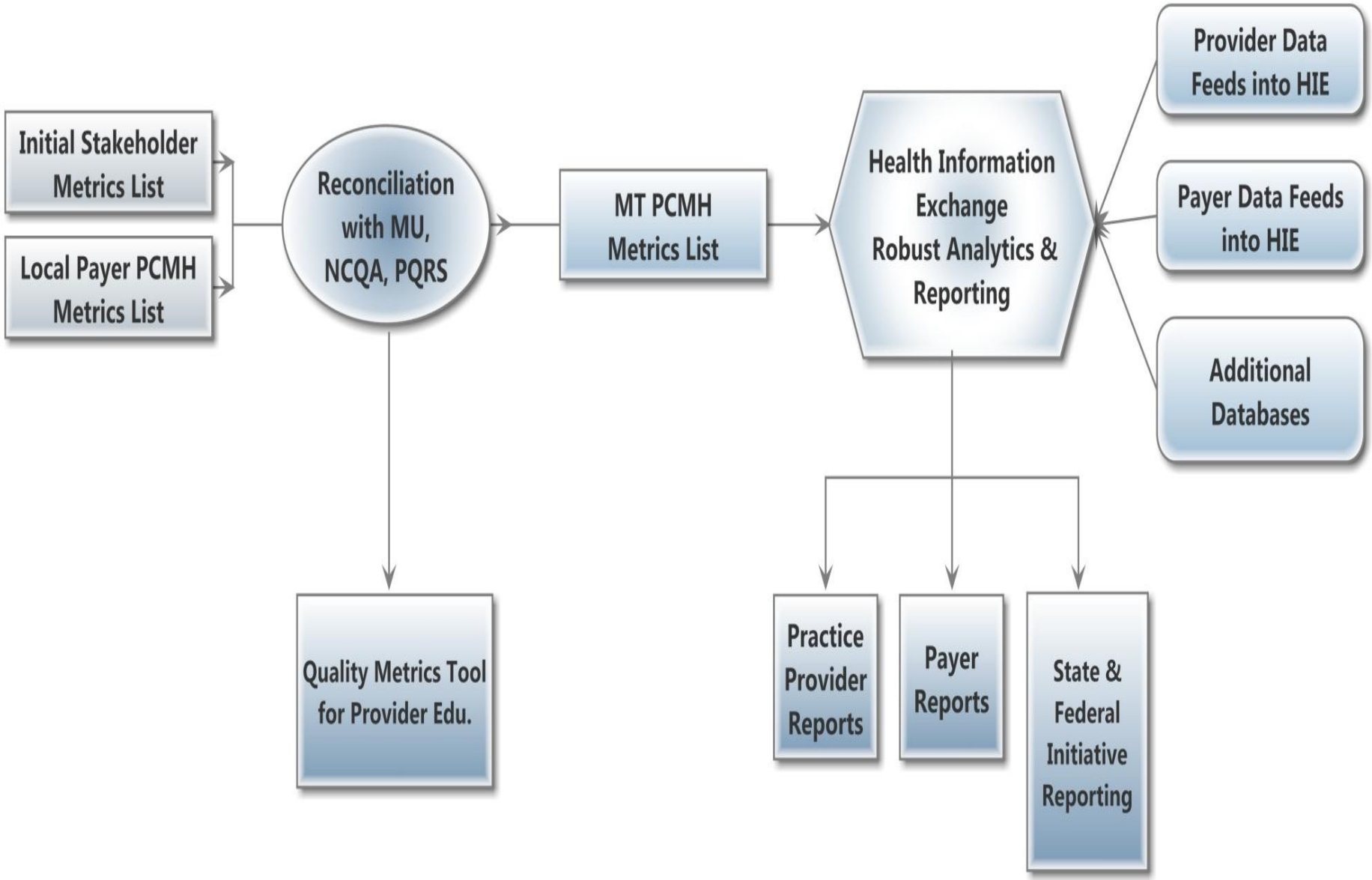
MT PCMH Quality Metrics Subcommittee Goals & Strategies

Subcommittee Goals	External Realities	Subcommittee Strategies
Add value to MT provider data management transformation strategies	Quality Metrics Programs are overwhelming	<u>Metric Selection Alignment</u> Incentive program requirements (MU, PQRS, local payer) *with* Meaningful outcomes-oriented metrics for practice transformation
Maintain uniformity among local payer and provider quality metrics selection as focus points of improvement efforts	Quality Metrics Programs are continually changing	<u>Provider Education</u> Technology platform requirements Data entry, aggregation, retrieval and reporting practices to meaningfully drive change
Help MT providers adapt information systems to accommodate/automate quality program requirements	**Primary Care is Dispirited** and bears the brunt of reporting requirements	Align MT PCMH Metrics *with* Financial Incentives (MU, PQRS, local payer)
Promote provider understanding of existing quality metrics program requirements and incentives	MU, PQRS, NCQA, local payer programs are ambulatory provider organization priorities	Crosswalk Quality Metrics Program Requirements

MT PCMH Quality Metrics Implementation Plan



Stage 1 Meaningful Use (MU) Objectives for EPs only		NCQA PCMH 2011 Standards	2012 Physician Quality Reporting System (PQRS)
The measures listed below are the requirements for Eligible Professionals (EPs) only. Click here to access the CQM site		*To the extent possible, the PCMH standards are aligned with the CMS Meaningful Use requirements.*	*Click the link below to access the CMS PQRS site.* Click here to access the PQRS site
CORE 10: Clinical Quality Measures **CORE MEASURES**			
10.a NQF 0013	**Hypertension: Blood Pressure Measurement**		**PQRS 237 – EHR** **PQRS 317 – Registry and Claims** **Hypertension (HTN): Blood Pressure Measurement**
→	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.		Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN with blood pressure (BP) recorded.
10.b NQF 0028	**Preventive Care and Screening Measure Pair:** **a. Tobacco use Assessment** **b. Tobacco Cessation Intervention**	**PCMH 2: Element B.8** (Related Standard)	**PQRS 226 – Registry, Claims, EHR** (not exact match) * **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**
→ →	a) Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months. B) Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	The practice uses an electronic system to record the following as structured (searchable) data: 8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients.	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. *NQF 0028b requires patient to be seen for at least 2 office visits. PQRS 226 does not require 2 office visits.
10.c NQF 0421	**Adult Weight Screening and Follow-up**	**PCMH 2: Element B.6** (Related Standard)	**PQRS 128 – Registry, Claims, EHR** **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

MT PCMH Quality Metrics

Preventive Measures

Weight Management

NQF 0421
PQRS 128
NCQA 2, Element B6

Immunizations

Adults:
NQF 0041
PQRS 110
NCQA 2, Element C1

Children:
NQF 0038
PQRS 240
NCQA 2, Element B3,4,5

Tobacco

NQF 0028
PQRS 226
NCQA 2, Element B8

Cancer Screening

Colorectal:
NQF 0034
PQRS 113
NCQA 2, Element D1

Breast:
NQF 0031
PQRS 112
NCQA 2, Element D1

Chronic Disease Measures

Diabetes

NQF 0059
PQRS 1

Hypertension

NQF 0018
PQRS 244, 236

Coronary Artery Disease

NQF 0074
PQRS 197

Congestive Heart Failure

NQF 0081
PQRS 5

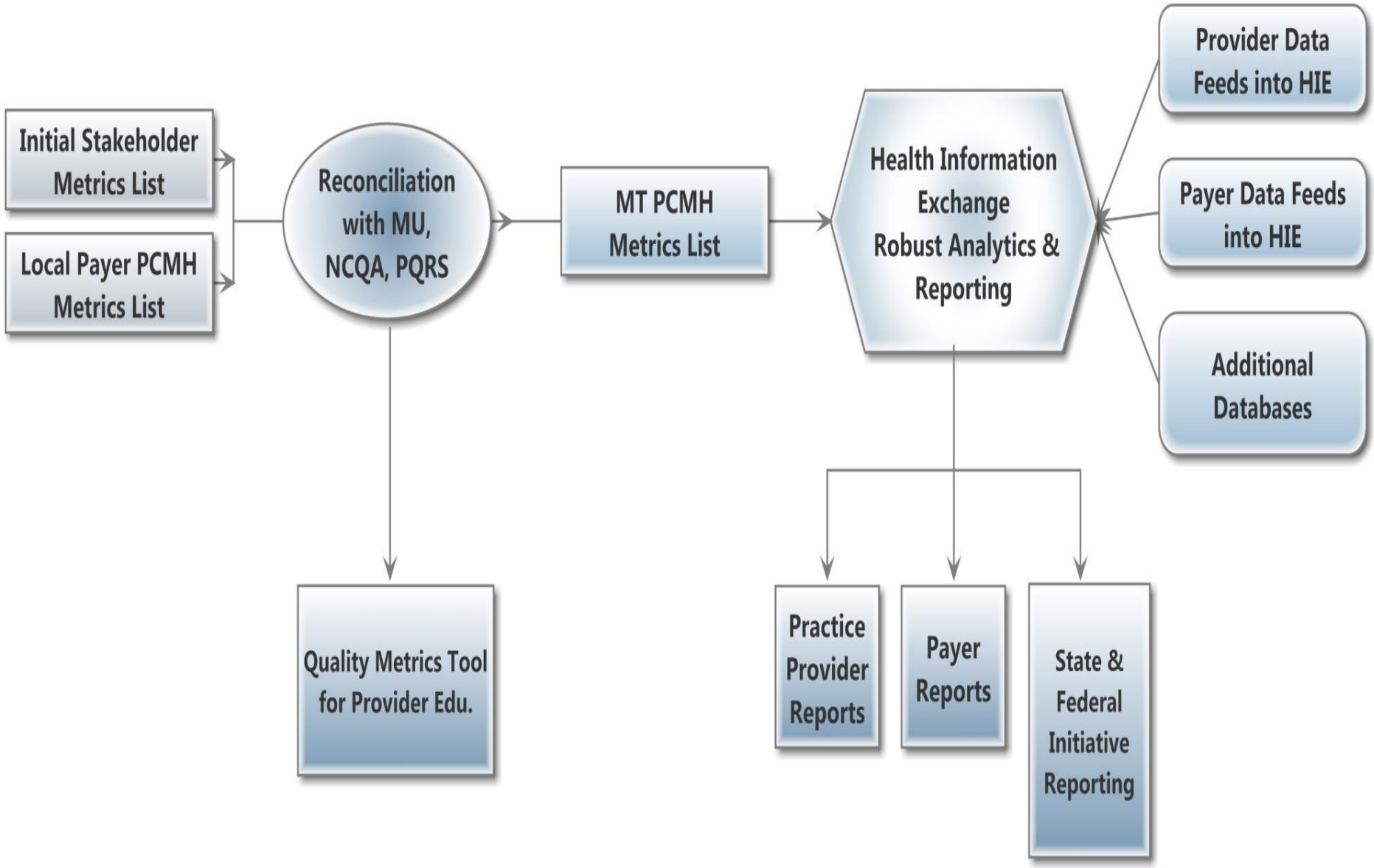
Chronic Obstructive Pulmonary Disease

NQF 0102
PQRS 52

Asthma

NQF 0036
PQRS 53

MT PCMH Quality Metrics Implementation Plan



In recent poll of Montana providers and health care organizations,

HealthShare Montana was selected as HIE and data repository of choice for the Montana Patient-Centered Medical Home

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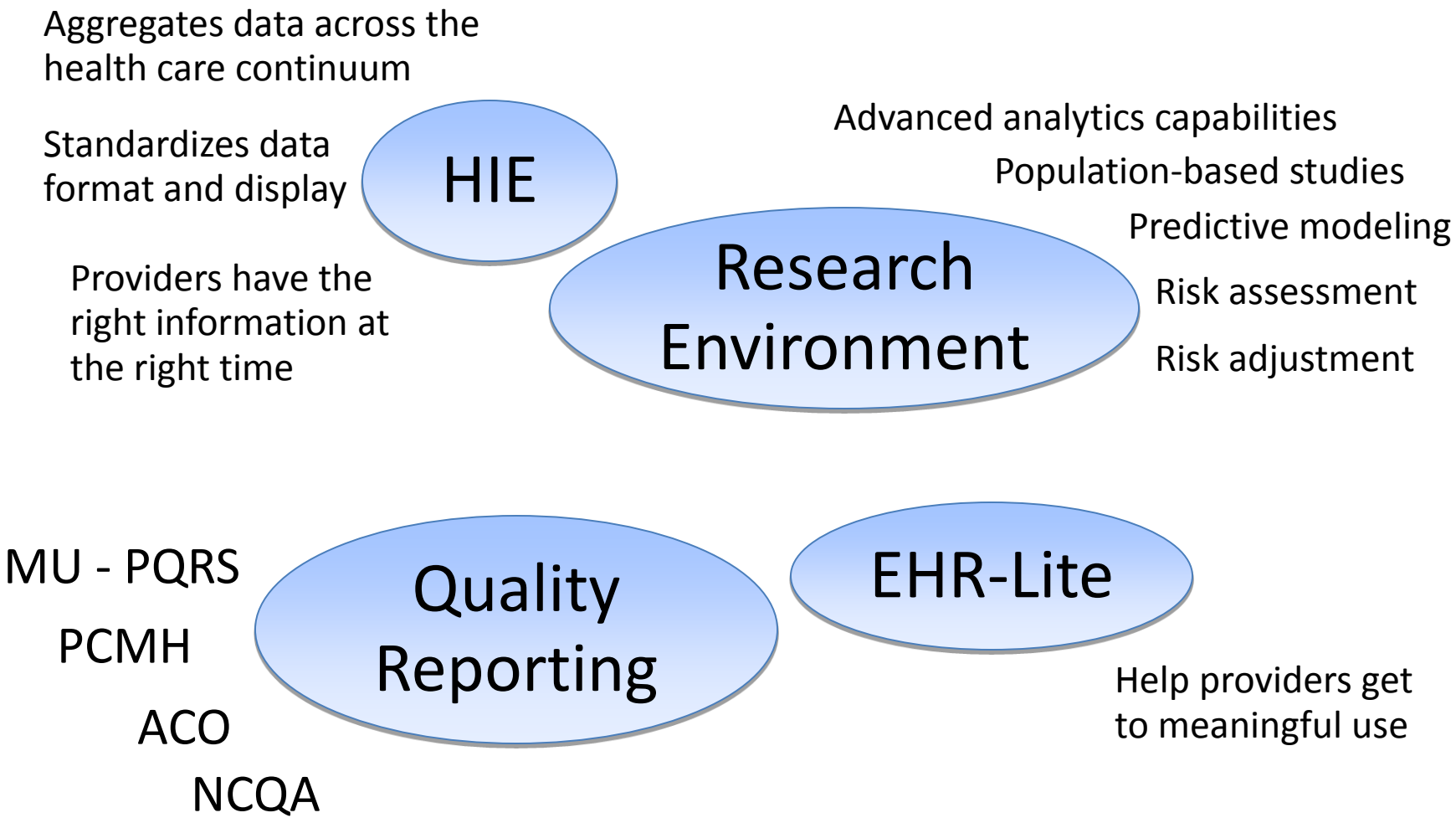
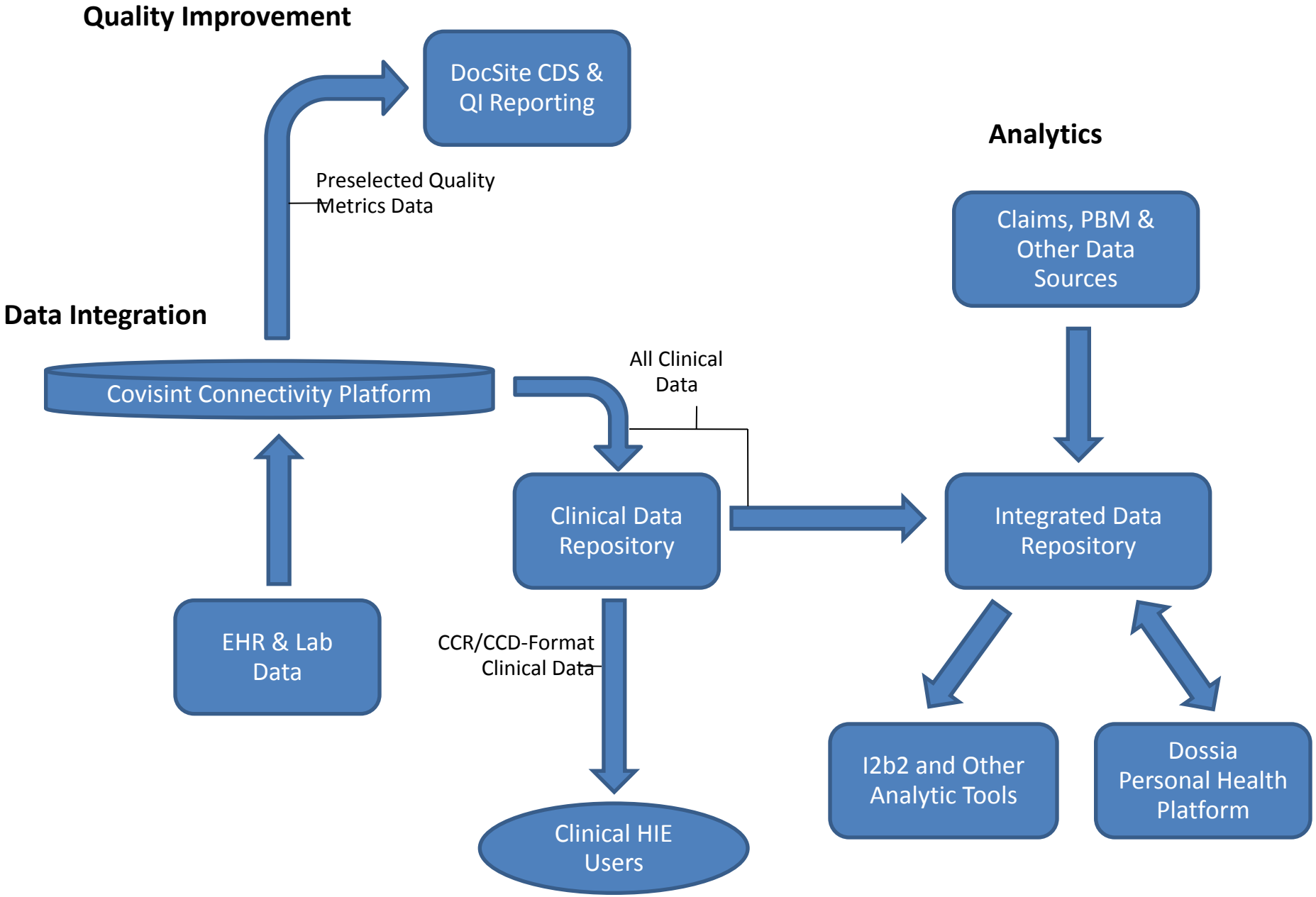
HealthShare Montana



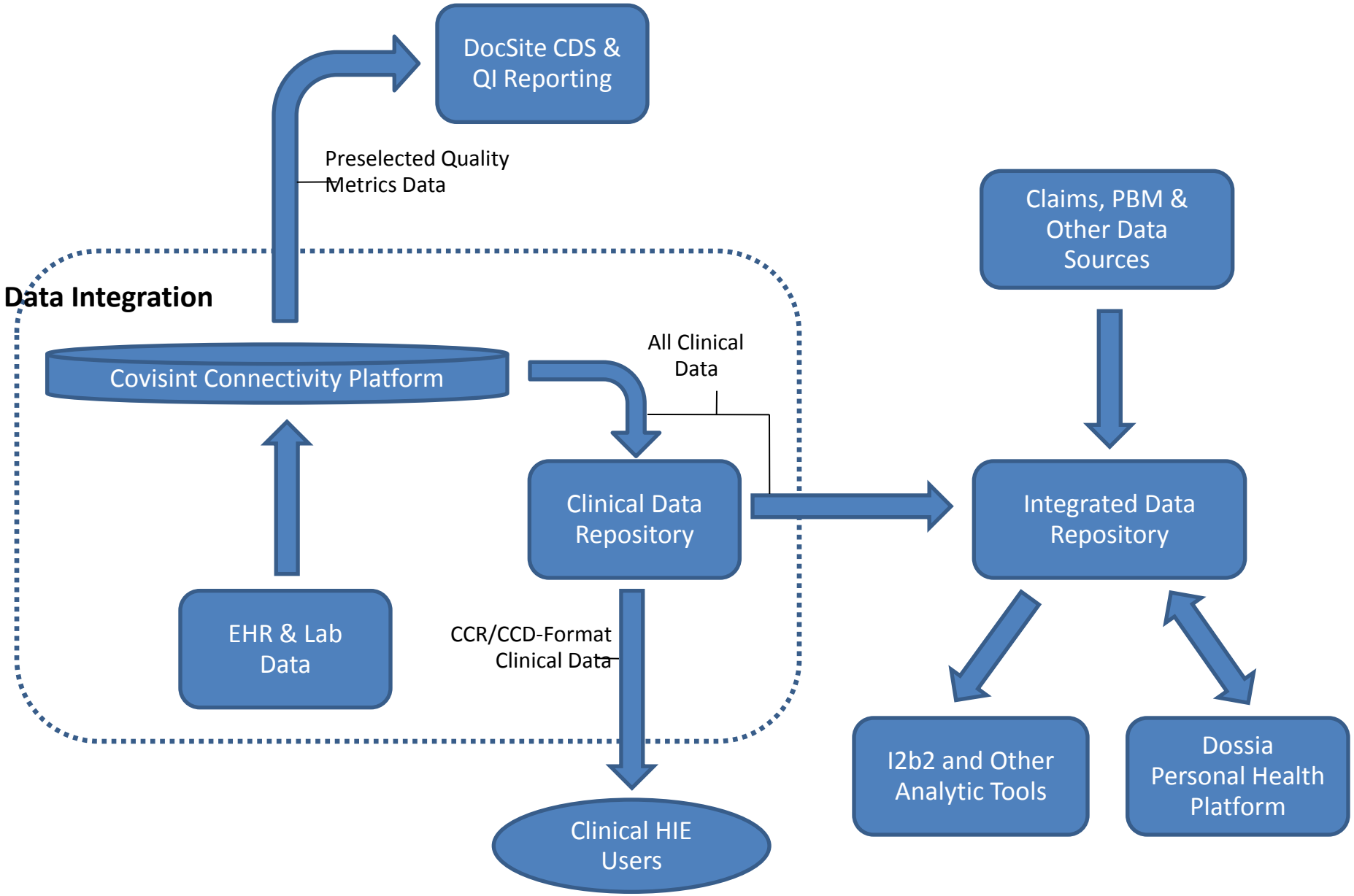
HSM Infrastructure & Data Use: Data Integration, Quality Improvement & Analytics



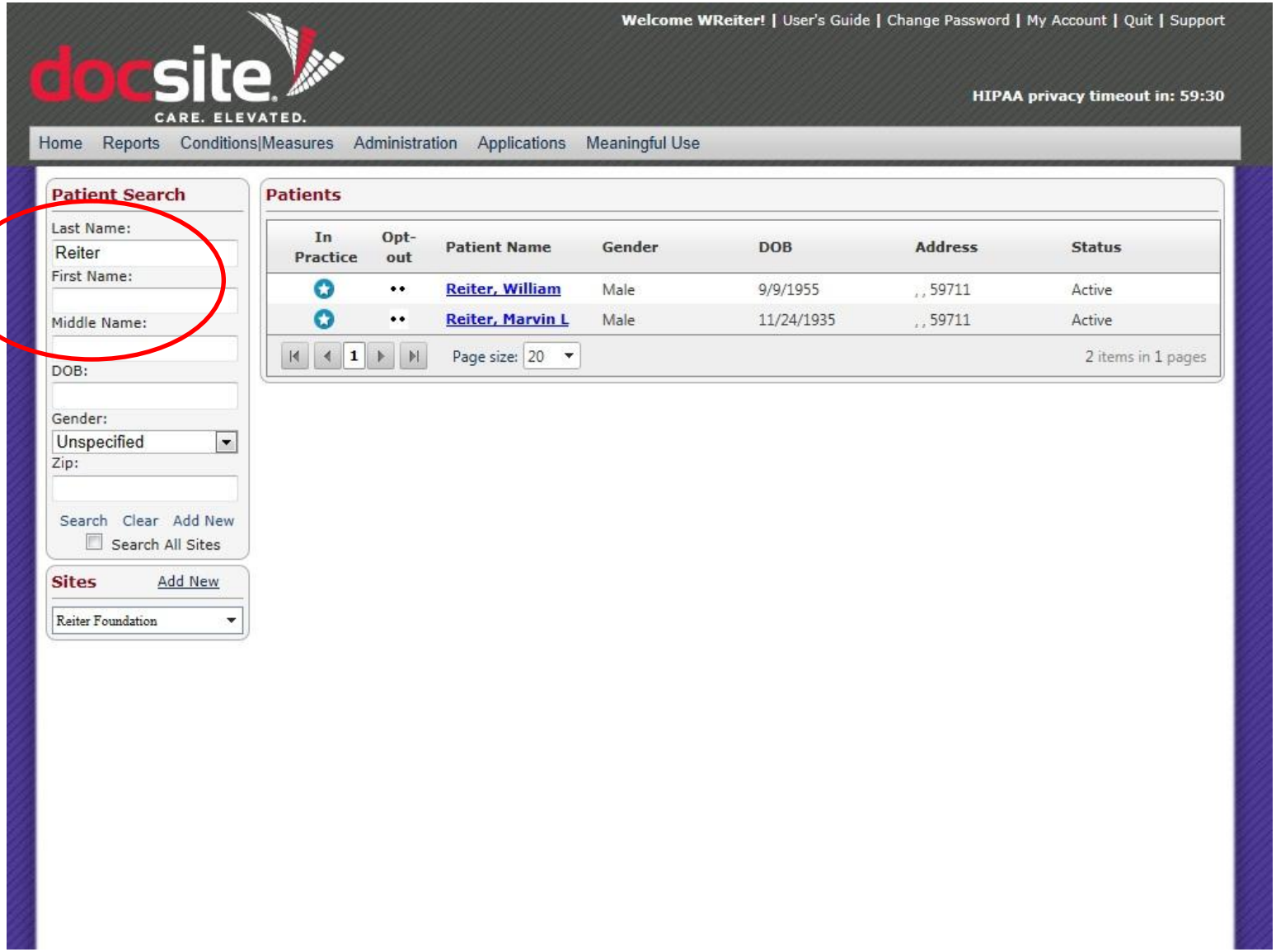
HSM Platform Capabilities

Rapid Connections via Standards-Based Interfaces	Conforms with National HIE Standards Capable of Reporting	<u>Supports</u>: Business Intelligence Tools Analytics

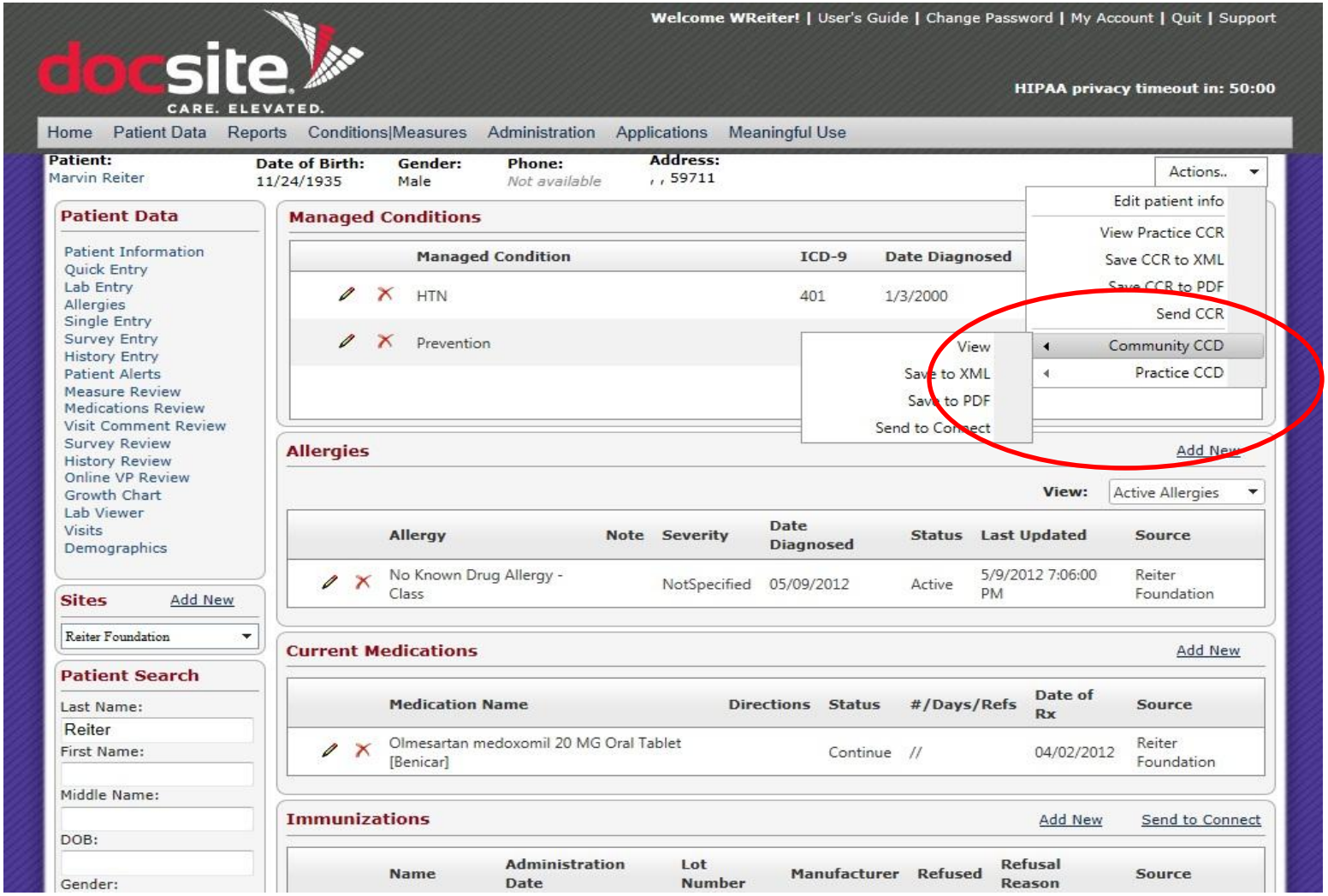
HSM Infrastructure & Data Use: Care Transition, Quality Improvement & Analytics



On-Demand HIE Patient Search/Query Screen



Access to CCR/CCD Information for Care Transition



Example of an Encounter-Based CCR Summary

Continuity of Care Record

Date Created: Thu May 17, 2012 at 05:09 PM UTC-05:00

From: William Reiter MD (System User)
William Reiter MD (Principal Provider)
Reiter Foundation (Care Facility)
DocSite Patient Planner V3 (Healthcare Information System)

To:

Purpose:

Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address / Phone
Marvin L Reiter	Nov 24, 1935	Male	DocSiteID 1011459	**Home:** 59711

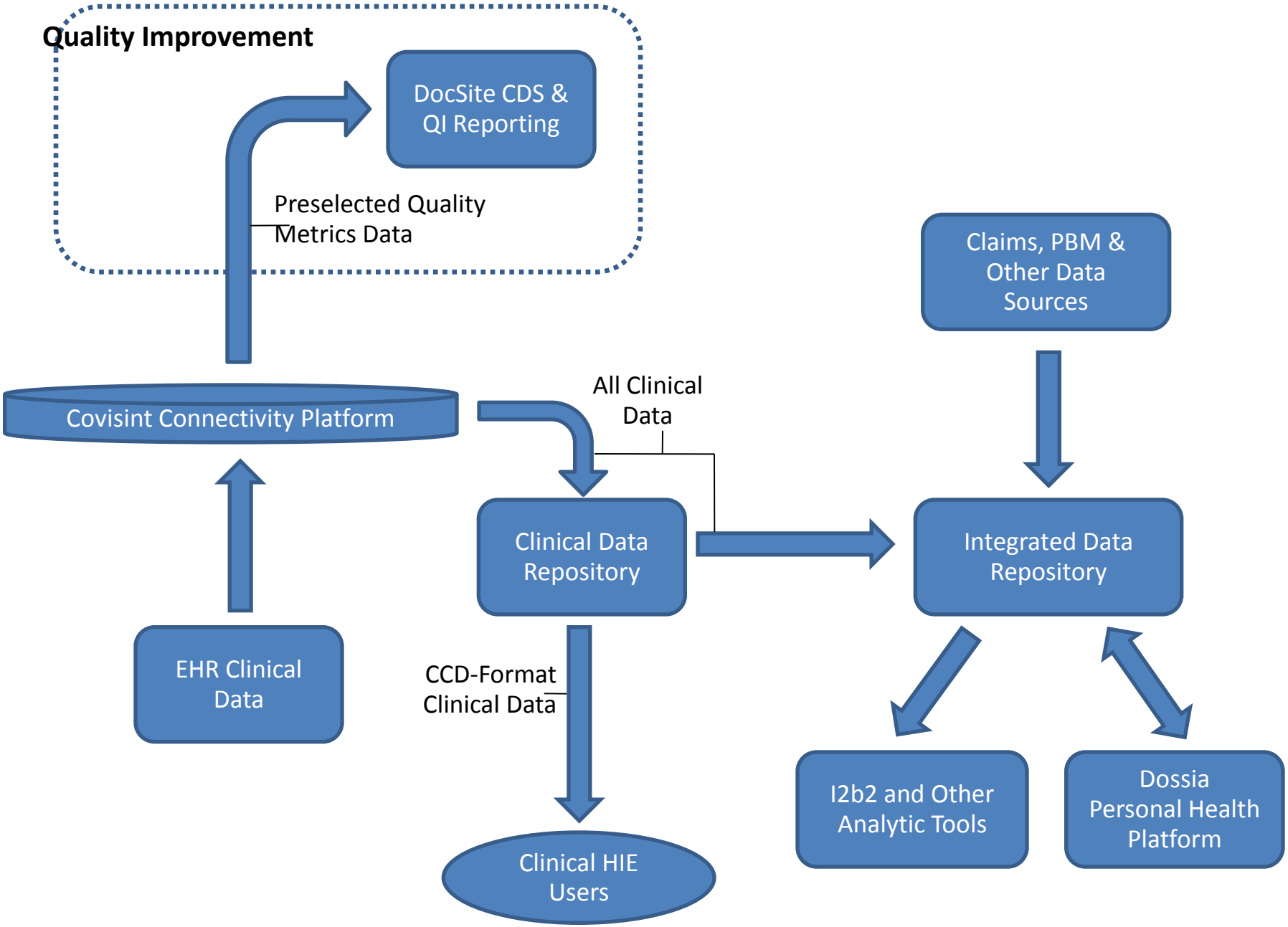
Alerts

Type	Date	Code	Description	Reaction	Source
Allergy	May 09, 2012		**No Known Drug Allergy - Class**	-NotSpecified	Marvin L Reiter
Alert	May 09, 2012	BP SBP (DocSite Codes)	**BP SBP: 144 mmHg [Ref - < 130]**		Marvin L Reiter
Alert	May 09, 2012	BP DBP (DocSite Codes)	**BP DBP: 92 mmHg [Ref - < 80]**		Marvin L Reiter
Alert	May 09, 2012	HTN - Non-Rx Plan (DocSite Codes)	**HTN - Non-Rx Plan: ExcerciseUp [Ref - NA]**		Marvin L Reiter
Alert	Jan 17, 2012	PQRI 226 (DocSite Codes)	**PQRI 226: Tobacco Non-User [Ref - NA]**		Marvin L Reiter
Alert	May 09, 2012	Today's Visit Type (DocSite Codes)	**Today's Visit Type: Planned visit [Ref - NA]**		Marvin L Reiter
Alert	May 09, 2012	Exercise Duration (min) (DocSite Codes)	**Exercise Duration (min): 20 # min [Ref - NA]**		Marvin L Reiter

Problems

Type	Date	Code	Description	Status	Source
Condition	Jan 03, 2000	401 (ICD9-CM)	**HTN**	Active	DocSite Patient Planner V3
Condition	May 09, 2012		**Prevention**	Active	DocSite Patient Planner V3

HSM Data Infrastructure: Care Transition, Quality Improvement & Analytics

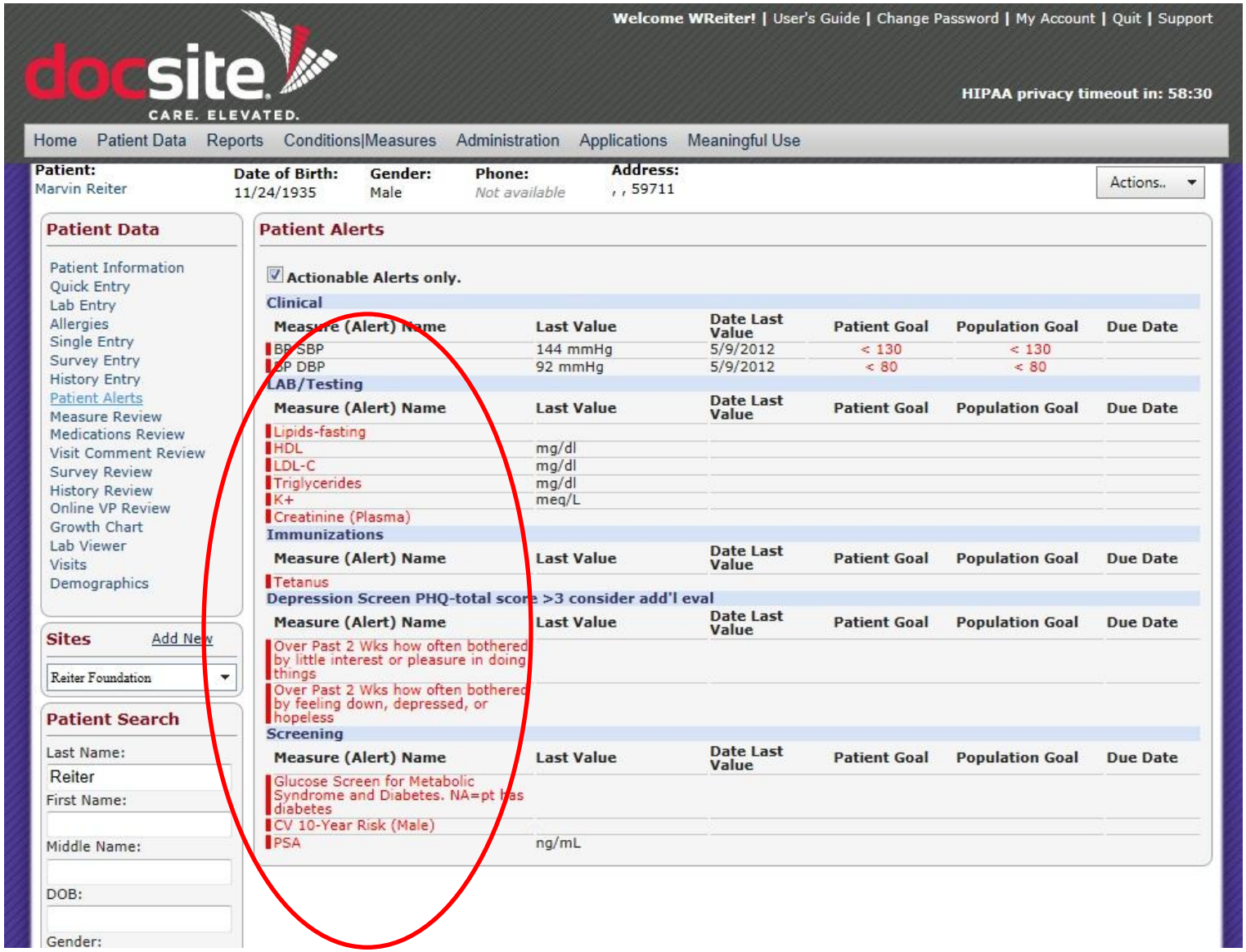


Meaningful Use (MU) & National Committee for Quality Assurance (NCQA) Requirements

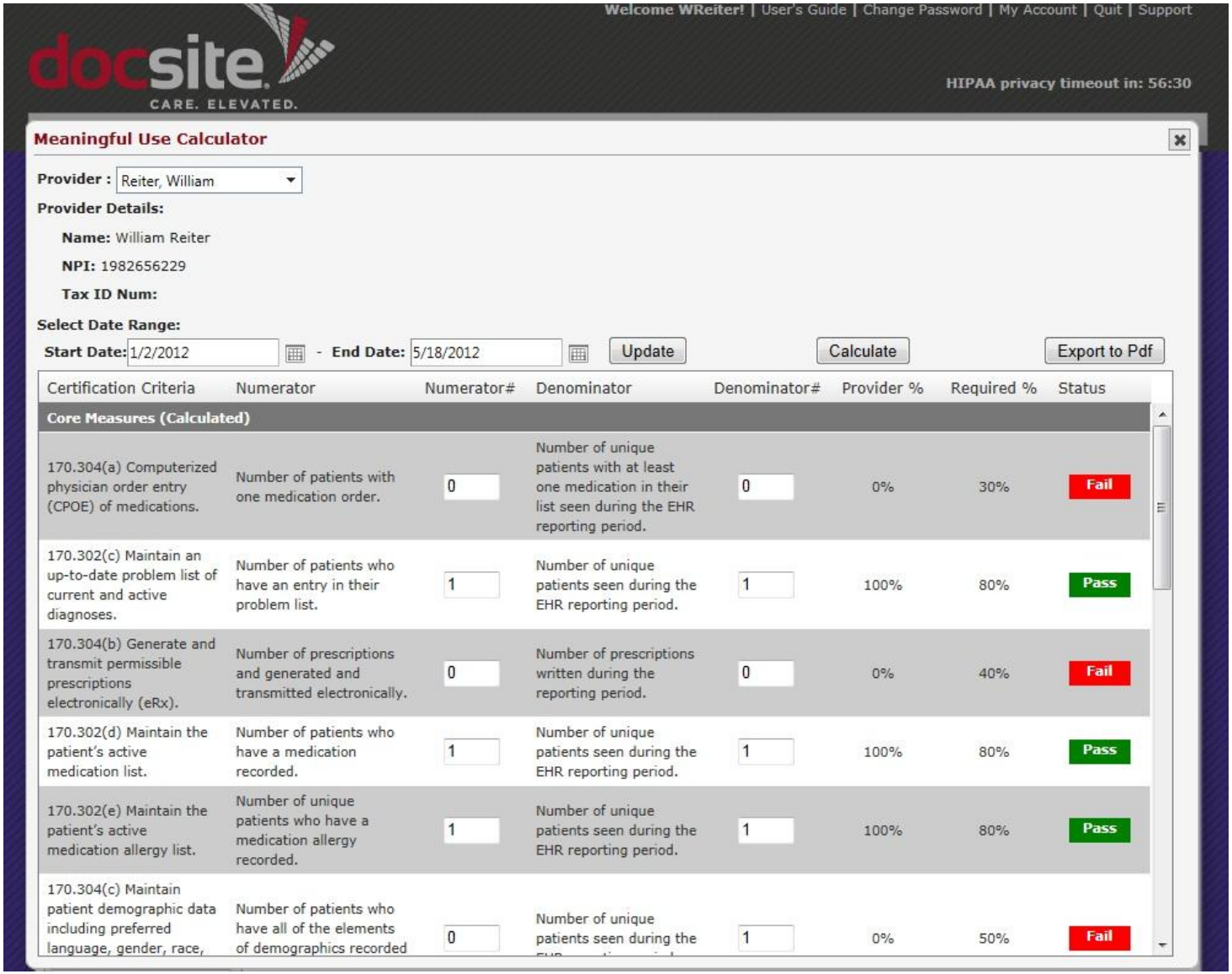
*"Most physicians are very interested in and responsive to accurate evidence. Being able to interrogate one's own data for rates of performance on quality measures could lead to significant healthcare improvements."**

*REPORT TO THE PRESIDENT
REALIZING THE FULL POTENTIAL OF HEALTH INFORMATION TECHNOLOGY
TO IMPROVE HEALTHCARE FOR AMERICANS:
THE PATH FORWARD
President's Council of Advisors on Science and Technology
December 2010

CDS for Identifying Unmet Needs & Improving Outcomes



Meaningful Use Calculators



Patient Outreach Report for Alerts

DocSite | Enterprise™

Outreach Report: Phone

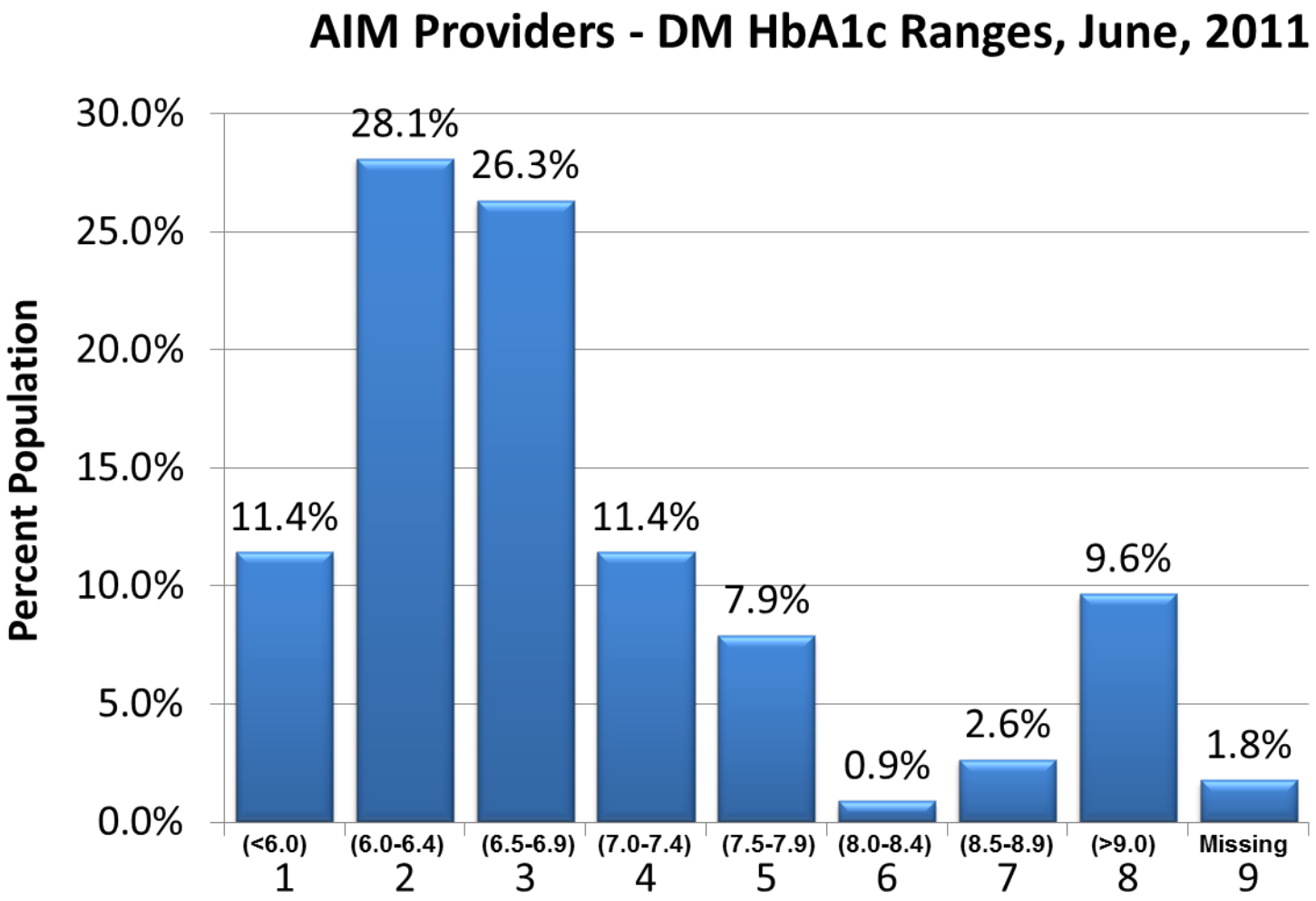
Print Date: 5/17/2012

Number Of Patients: 1

Name	Gender	DOB (Age)	MRN:	Phone	Conditions	Provider	Measure	Value	Pt. Goal	Eval Date	Due Date
Reiter,Marvin	Male	11/24/1935 (76)	Not Entered		HTN, Prevention		BP SBP	144	< 130	5/9/2012	
							BP DBP	92	< 80	5/9/2012	

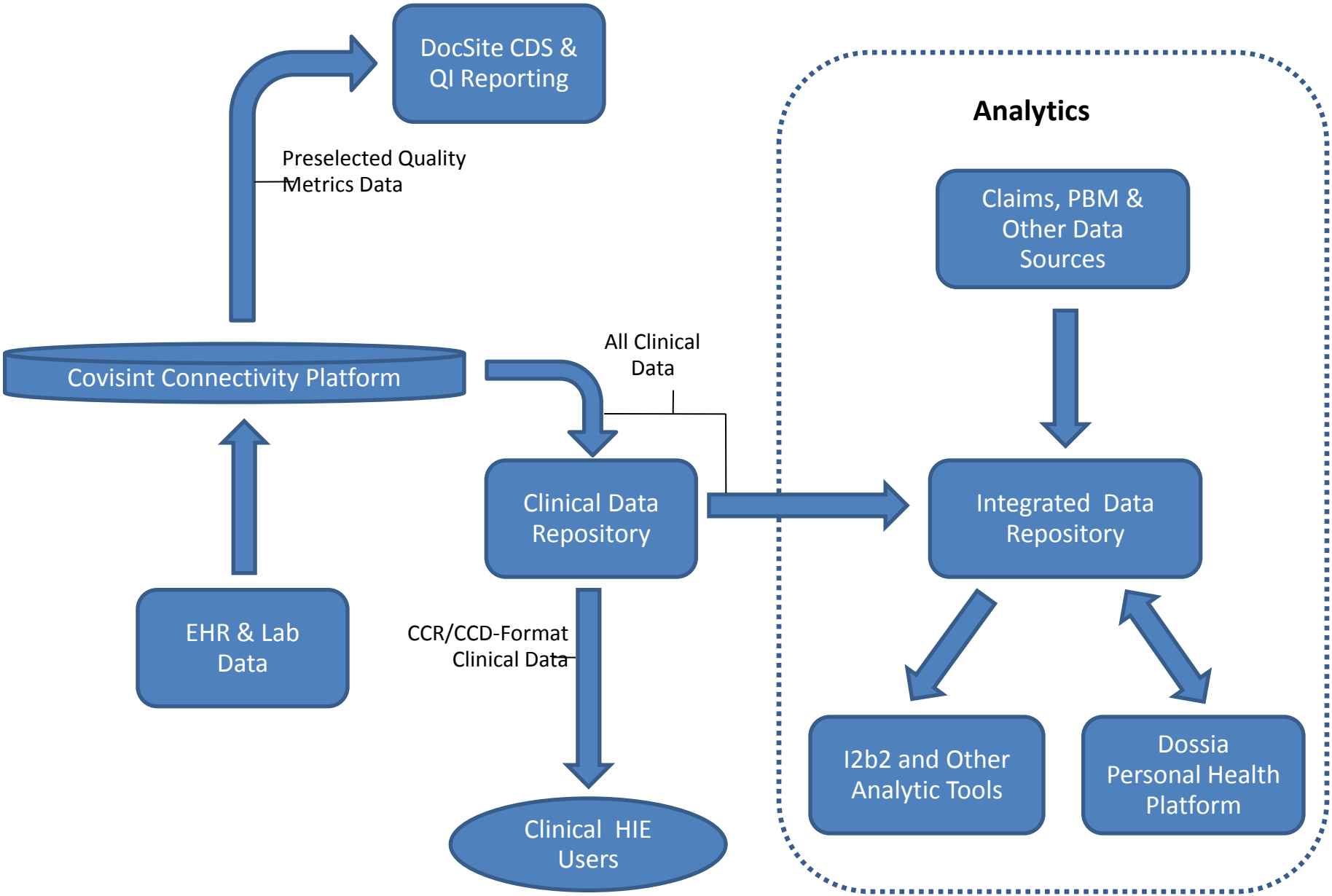
Number Of Patients: 1

Example of Population Report, DM HbA1c

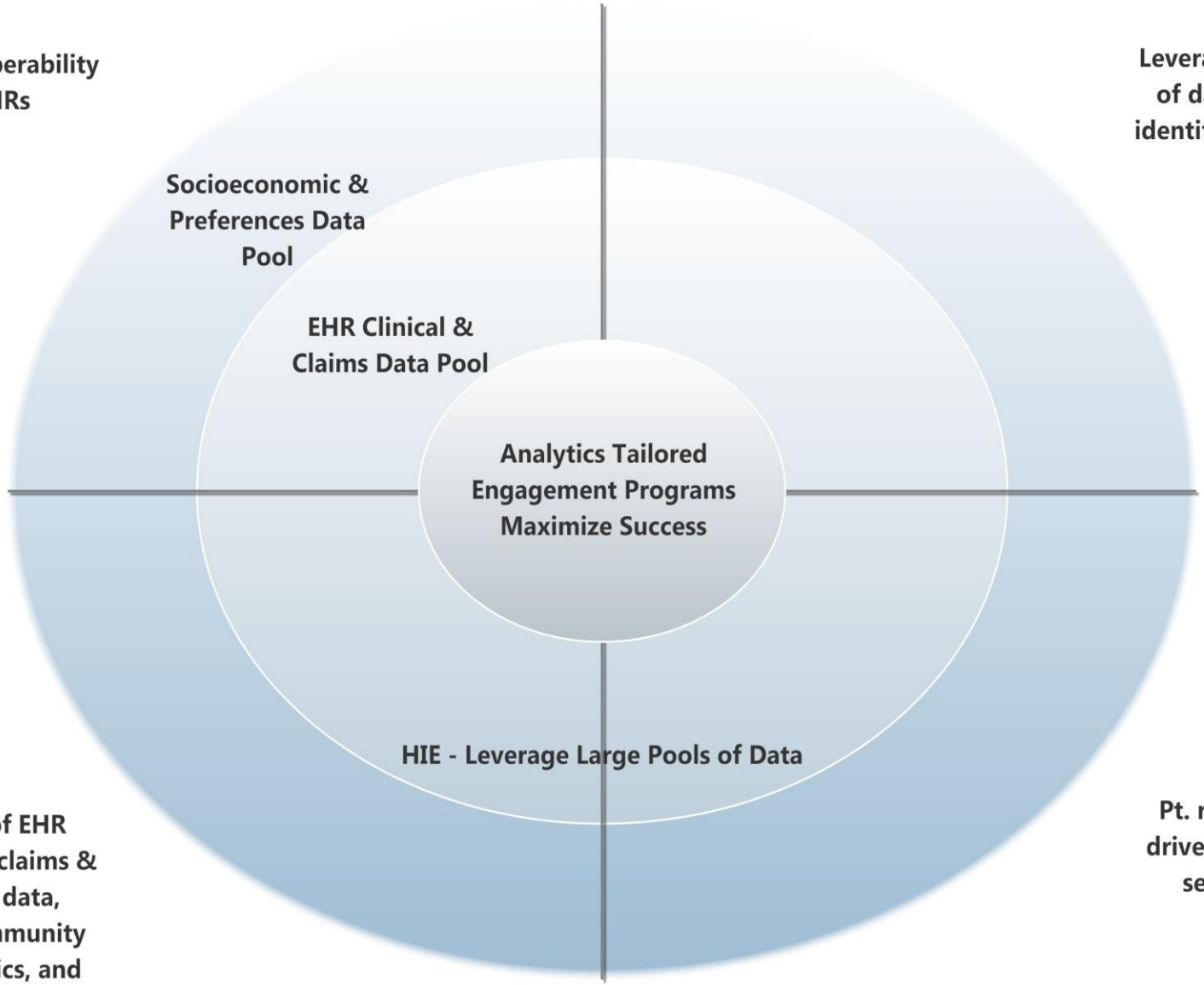


QC 2010: *HbA1c < 7.0%* - **42.10%**
BCBS MT 2010: *HbA1c < 7.0%* - **47.23%**
AIM (March) 2011: *HbA1c < 7.0%* - **65.79%**

HSM Infrastructure & Data Use: Care Transition, Quality Improvement & Analytics



HIE & Analytics-driven insights to understand individuals and develop targeted engagement strategies



Resources

- CSI *800-332-6148*
  - www.csi.mt.gov
- Regional Extension Center (REC) *406-457-5888*
  - www.healthtechnologyservice.com
- Mountain Pacific Quality Health *406-443-4020*
  - www.mpqhf.org
- Health Share MT *406-794-0170*
  - www.healthsharemontana.org
- NCQA *202-955-5128*
  - www.ncqa.org

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Thank you for joining the webinar today! Questions?

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